

U. A. LOCAL NO. 159 DEFINED CONTRIBUTION PLAN
APPLICATION FOR DEATH BENEFITS
4160 Dublin Blvd., Suite 400, Dublin, CA 94568
Telephone: (866) 295-6402

Please read and complete each item. Print or type your answers (except signatures). Mark "N/A" (Not Applicable) if the requested information does not apply to you. Sign and date the Application. Mail the completed Application and required attachments to the Plan Office at the address above. **Be sure that your answers are accurate.** Incorrect or incomplete information will delay receipt of your benefits.

1. Name of Deceased _____
Last First Middle
2. Soc. Sec. No. of Deceased _____
3. Date of Death _____
4. Marital Status of Deceased: Single_____ Married_____ Separated_____
(Check whatever applies): Divorced_____ Widowed_____ Unknown_____
5. Your Name _____
Last First Middle
6. Your Address _____
No. and Street

City State Zip Code
7. Your Telephone No. _____
8. Your Soc. Sec. No. _____
9. Your Date of Birth _____
10. Your Relationship to Deceased _____

In addition to this Application, you must submit the following documents:

- ☐ A certified Death Certificate.
- ☐ If you were married to the deceased on the date of death, your marriage certificate.
- ☐ If you were married to the deceased and later divorced, complete copies of the Judgment of Dissolution of Marriage, marital settlement agreement and any Qualified Domestic Relations Orders.
- ☐ If you are the child of the deceased, your birth certificate.

DECLARATION AND CLAIM FOR BENEFITS

I declare under penalty of perjury that I qualify to receive death benefits payable under the Plan, because I am a member of the following category of beneficiaries of the deceased

- (Circle one):
1. surviving spouse
 2. designated beneficiary
 3. former spouse
 4. child
 5. parent
 6. sister or brother
 7. other (explain): _____

I further declare that I know of no other person in the category of persons I have circled above, or in a category above the category I have circled, except for the persons I have listed below.

<u>Name</u>	<u>Address</u>	<u>Category</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify, under penalty of law, that all of the above statements on this Application and all of the statements on the attached pages and documents are true, correct and complete, to the best of my knowledge. I understand that a false statement may disqualify me for benefits and that the Trustees have the right to recover any payments made to me because of a false statement.

_____ Signature of Claimant	_____ Date
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**Your signature must be notarized or witnessed by a Plan representative.
Attach notary certificate here if not signed below.**

_____ Signature of Plan Representative	_____ Date
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